



Barrier Islands Free Medical Clinic, Inc.
3226 Maybank Highway Suite A
Johns Island, SC 29455
P: 843-266-9800 F: 843-266-9801

Medical Volunteer Application

Contact Information

Name	
Street Address	
City, State, Zip	
Home Phone	
Cell Phone	
Office Phone	
Email Address	
Preferred Method of Contact	

Availability

What days and times are you available to volunteer? If you live here part-time please complete the "Other" section.

Days

- Monday
 Tuesday
 Wednesday
 Thursday
 Friday

Hours

- 6:00 pm - 9:00 pm (Monday only)
 9:00 am - 1:00 pm (T, W, Th, F)
 1:00 pm - 4:00 pm (W, Th, F)

Other

- During the time I am in SC
Months: _____
Days: _____

Are You a Licensed:

- Doctor Nurse Nurse Practitioner Physician's Assistant

Previous Volunteer Experience

Please summarize your previous volunteer experience.

Please Provide the Following:

DEA Number _____

NPI Number _____

Medical License Number _____ *OR* Volunteer Limited License Number _____

Are You Licensed in Any Other State? ___ Yes ___ No

If "Yes", Which One(s)? _____

Are You Currently Covered by Medical Practice Insurance? ___ Yes ___ No

If Not, Do You Carry a Tail from Previous Coverage? ___ Yes ___ No

Have You Incurred Any Malpractice Claims During the Last 10 Years? ___ Yes ___ No

Have You Ever Been Convicted of a Felony? ___ Yes ___ No

Background Checks

The Clinic requires all volunteers to undergo appropriate background checks. For medical volunteers, we check SLED, the Medical Licensing Board and the National Practitioner Data Bank. Please provide your date of birth for these background checks.

Date of Birth _____

Person to Notify in Case of Emergency

Name	
Street Address	
City, State, Zip	
Home Phone	
Work Phone	
Cell Phone	
Email Address	

Agreement and Signature

By submitting this application, I understand that as a volunteer, I will give of my time and talents to the mission of the Barrier Islands Free Medical Clinic, Inc. to provide medical care for the uninsured population of Johns, Wadmalaw and James Islands, without compensation. I agree to undergo all required background checks and to abide by current HIPPA legislation.

Print Name	
Signature	
Date	

Please Provide Your Driver's License, Your Medical License or Volunteer Limited License and any License from Another State for Photocopying by Clinic Staff.

Please Provide a Copy of Your CV.